Part 6: Objective Based Allocation (OBA)

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Section 6.1: OBA Overview and Development

In 2007, DDRS and an external group of stakeholders consisting of advocates, providers, and industry professionals began the research and development of an objective based allocation method.

Development strategy included baseline research, provider cost reporting, modeling, assessment validation, pilots, and best practices. Modeling was used to determine the parameters for Algorithm development (Algos)

The Objective Based Allocation (OBA) is the method used by the state to determine the level of supports an individual needs in order to live in a community setting while receiving services under the Community Integration and Habilitation Waiver. The OBA is determined by combining the Overall Algo (determined by the ICAP and ICAP addendum), Age, Employment, and Living Arrangement. For more information on the OBA please refer to training modules that were offered as guidance on the implementation of this new method.

Note that the OBA methodology is not used with the already capped Family Supports Waiver.

Section 6.2: ICAP Assessment and Algo Level Development

The nationally recognized Inventory for Client and Agency Planning (ICAP) was selected to be the primary tool for individual assessment.

The ICAP assessment determines an individual's level of functioning for Broad Independence and General Maladaptive Factors. The ICAP Addendum, commonly referred to as the Behavior and Health Factors, determines an individual's level of functioning on behavior and health factors.

These two assessments determine an individual's overall Algo level which can range from 0-6. Algos 0 & 6 are considered to be the outliers representing those who are the lowest and the highest on both ends of the functioning spectrum. Upon review, the State may manually adjust the designation of an individual from an Algo 5 to an Algo 6. While this Individual will continue receiving the Algo 5 budget, the Algo 6 designation indicates a need for additional oversight of the individual.

The Objective Based Allocation (OBA) is determined by combining the Overall Algo (determined by the ICAP and ICAP addendum), Age, Employment, and Living Arrangement.

The stakeholder group designed a building block grid to build the allocations. The building block grid was developed with the following tenets playing key roles: Focus on Daytime Programming; Employment; Community Integration; and Housemates.

After the assessments are completed and the information is received by the State, participants in the Community Integration and Habilitation Waiver program and their support teams are required to review the information and ensure that it accurately reflects them. Upon completion the participant will be notified of the allocation limit through their case manager.

Individual teams may request a formal review of their allocation through their case manager. Teams are
asked to review the ICAP and ICAP addendum and provide supporting documentation to substantiate an
individual's need for placement in a different Algorithm level. The supporting documentation is reviewed as well as the Person Centered Planning Document, Individualized Service Plans, Behavior Support Plans, High Risk Plans and any other collateral documentation needed to analyze the individual's Algorithm level.

Section 6.3: Budget Review Questionnaire (BRQ) and Budget Modification Review (BMR)

Applicable only to the Community Integration and Habilitation Waiver program, "Budget Review Questionnaire" means a set of qualifying questions to determine why a budget review is necessary. The Budget Review Questionnaire is submitted by the individual's case manager based on information provided by the Individualized Support Team.

Adjustments to the allocation limit may also occur when the participant has a change in their needs. Individual support teams may request a review of the assigned allocation limit through their case
manager via a Budget Review Questionnaire (BRQ). The individual support teams must first review the functional assessment findings and provide any other supporting documentation that might lead to an adjustment in the allocation limit. When requested, reviews are conducted by a personal allocation review team within DDRS. If appropriate, adjustments and/or recommendations are provided by the DDRS review team. In addition, a Budget Modification Review (BMR) allows the participant to request short term increases in funding beyond the allocation limit if specific conditions apply. These conditions consist of a change in medical or behavioral needs or a change in living arrangement.

The BMR provides the participant in the Community Integration and Habilitation Waiver program the ability to request additional funding for a short amount of time to meet their needs that are outside the original allocation limit funding amount.

An individual or their legal representative may appeal the Algo if they feel it is inaccurate. The consumer/legal guardian has the right to appeal any waiver-related decision of the state within 33 days of Notice of Action (NOA). A Notice of Action (NOA) is issued with the release of each

State decision pertaining to a Plan of Care/Cost Comparison Budget (CCB). Each NOA contains the appeal rights of the consumer as well as instructions for filing an appeal.

The BMR process is in place for waiver consumers who experience circumstances where additional funds are needed for short-term, unanticipated situations. Each initial event requested, if approved, shall not exceed ninety (90) days.

In order for a BMR to be considered, the following must first be sought:

- Housemates
- Electronic Monitoring Service
- Medicaid Prior Authorization Services
- Natural Supports

The individual's case manager is responsible for submitting initial BMR.

BDDS will respond to a new BMR within seven (7) business days of submission.

- final decision on BMR will not be made until case manager responds to all inquiries from BDDS.

Note that the BRQ and BMR processes are <u>not</u> used with the already capped Family Supports Waiver.

BUDGET MODIFICATION REQUEST CATEGORIES (FOR CONSIDERATION)

- Loss of a housemate due to:
    - death;
    - extended hospitalization of fourteen (14) or more days;
    - nursing facility respite stay of fourteen (14) or more days;
    - incarceration of fourteen (14) or more days;
    - State substantiated abuse, neglect, or exploitation;
    - State intervention for behavioral needs;
    - State intervention for health or medical needs; or
    - housemate changes Providers.

- Loss of employment.

- State substantiated abuse, neglect, or exploitation.

- Behavioral needs requiring State intervention.

- Health or medical needs requiring State intervention.

DOCUMENTATION REQUIREMENTS

Documentation requirements for Budget Modification Requests include, but are not limited to the following:

- If increased behaviors result in a BMR, documentation regarding changes to the consumer's behavior plan, staff trainings, etc. will be required within 30 days of the request for the BMR to be considered.

    - If behaviors are anticipated to last longer than ninety (90) days, a Budget Review Questionnaire should be completed rather than a BMR.

- In order for a BMR to be considered in Crisis situations a consumer must first go through the Crisis process.

- Individualized Support Teams (ISTs) must work together to address the individual's need and develop a long term plan within the individual's resources.

    - ISTs will be asked to submit these long term plans and objectives for all additional Budget Modification Requests.

Section 6.4: Assessment (Algo) Level Descriptors

Assessment (Algo) Level Descriptors

Level	Descriptor
0 Low	**High level of independence (Few Supports needed). No significant behavioral issues. Requires minimal Residential Habilitation Services.**
1 Basic	**Moderately high level of independence (Limited supports needed). Behavioral needs, if any, can be met with medication or informal direction by caregivers (through the use of Medicaid state plan services). Although there is likely a need for day programming and light Residential Habilitation Services to assist with certain tasks, the client can be unsupervised for much of the day and night.**
2 Regular	**Moderate level of independence (Frequent supports needed). Behavioral needs, if any, met through medication and/or light therapy (every one to two weeks). Does not require 24-hour supervision – generally able to sleep unsupervised – but needs structure and routine throughout the day.**
3 Moderate	**Requires access to full-time supervision (24/7 staff availability) for medical and/or behavioral needs. Behavioral and medical supports are not generally intense and can be provided in a shared staffing setting**
4 High	**Requires access to full-time supervision (24/7 frequent and regular staff interaction, require line of sight) for medical and/or behavioral needs. Needs are moderately intense, but can still generally be provided in a shared setting.**
5 Intensive	**Requires access to full-time supervision (24/7 absolute line of sight support). Needs are intense and require the full attention of a caregiver (1:1 staff to individual ratio). Typically, this level of services is generally only needed by those with intense behaviors (not medical needs alone).**
6 High Intensive	**Requires access to full-time supervision (24/7 more than 1:1). Needs are exceptional and for at least part of each day require more than one caregiver exclusively devoted to the client. There is imminent risk of individual harming self and/or others without vigilant supervision.**

Section 6.5: OBA Service Hours

The following OBA service hours are applicable only to Community Integration and Habilitation Waiver participants. Service hour increases announced August 24, 2012 do not take effect until January 1, 2013. The increases are reflected in the chart below and have been included in annual allocations applicable to 2013 anniversary dates.

	ALGO Level					
Individual RHS Daily Hours	**0**	**1**	**2**	**3**	**4**	**5 & 6**
	Low	**Basic**	**Regular**	**Moderate**	**High**	**Intensive & High Intensive**
Living with Family	0.2	2	3	5	7	8
Living with One Housemate	0.2	2.6	5.3	7.8	11	12
Living with Two Housemates	0.2	2.6	4.6	7.8	10.1	11
Living with Three Housemates	0.2	2.4	4.3	7.3	9.4	10
BMAN Reserve (Annual hrs)	0	0	36	72	108	144
Structured Family Caregiving ($/day)	51.87	51.87	75.87	102.87	102.87	102.87
Day Service Reserve ($/Yr)						
Not Attending School	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 10,500.00	$ 18,000.00
Attending School or under 19yrs.	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00	$ 5,500.00

Section 6.6: Implementation of Objective Based Allocations

Individuals participating in the Community Integration and Habilitation Waiver program will receive their new OBA on their annual renewal date. The first group will be the January 1st population. Over the course of 12 months, all waiver participants will be transitioned to an OBA when their waiver is up for annual renewal.

Allocations will receive a pre-release review focusing on individuals whose allocations drop or increase significantly from their previous cost comparison budget.

Training on the OBA can be found on FSSA website at http://www.in.gov/fssa/ddrs/4194.htm

Note that the OBA is not used with the Family Supports Waiver.

Section 6.7: PAR Review and The Appeal Process

Applicable only to participants in the Community Integration and Habilitation Waiver program, an individualized support team may request a PAR (Personal Allocation Review) through the Case Manager via BRQ (Budget Review Questionnaire). The BRQ states the reason for allocation review; i.e. Algo level is incorrect; ICAP assessment has significant error; ICAP Addendum (Behavior and Health Factors) are incorrect; living arrangement is incorrect; etc. The BRQ is submitted to the district BDDS office for review and then submitted to the PARS unit for a PAR review.

If an individual has not received their BRQ results back prior to the new plan start date, the case manager may request a BMR monthly until the BRQ results are completed by the PAR unit.

The PAR reviewer will notify the case manager of any change in Algo or allocation based on their review.
Note that PAR reviews are not available under the Family Supports Waiver.

If the individual support team is unhappy with the PAR review, or wishes to appeal without a PAR review, they may appeal one or more of the OBA components after their NOA (Notice of Action) has been generated: The ICAP Assessment; ICAP Addendum (Behavior and Health Factors) are incorrect; or Living Arrangement.

Note that upon receiving an official notice of appeal, the budget is locked by the PAR Unit. Please carefully read "The Right to Appeal and Have a Fair Hearing:"at the end of Section 6.7. **If your benefits are continued during the appeal process and you lose the appeal, you may be required to repay assistance paid in your behalf during the appeal process.**

To generate a NOA, a CCB must be submitted at the allocation level or the IST cannot submit a CCB and a default CCB will generate the NOA.

The appeal process, which has not changed with the OBA, is located on the back pages of the NOA and is stated below:

Your Appeal Right as an Applicant for HCBS Benefits

If you question the indicated decision, you should discuss this matter with your Case Manager.

Your Right to Appeal and Have a Fair Hearing:

> The Notice of Action provides an explanation of the decision made on your application for services or changes in your services. If you disagree with the decision, you have the

right to appeal by submitting a request for a Fair Hearing. Your Home and Community Based Services (HCBS) benefits will continue if your appeal is received within the required time frame described below under "How to Request an Appeal". If you appeal and your benefits are continued and you lose the appeal, you may be required to repay assistance paid on your behalf pending the release of the appeal hearing decision.

How to Request an Appeal:

1) If you wish to appeal this decision, the appeal request must be received by close of business not later than:

(1) 33 calendar days following the effective date of the action being appealed; or

(2) 33 calendar days from the date of the notice of agency action, whichever is later.

To file an appeal, please sign, date and return the Hearings & Appeals copy of this form to:

Indiana Family and Social Services Administration
Office of Hearings and Appeals
MS 04
402 W. Washington St., Room W392
Indianapolis, IN 46204

or via facsimile to 317-232-4412

If you are unable to sign, date, and return this form to the above mentioned address, you may have someone assist you in requesting the appeal.

2) You will be notified in writing by the Indiana Family and Social Services Administration, Hearings and Appeals office of the date, time, and location for the hearing. Prior to, or at the hearing, you have the right to examine the entire contents of your case record maintained by the Case Manager.

3) You may represent yourself at the hearing or you may authorize a person to represent you, such as an attorney, relative, or other spokesperson. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances, advance any arguments without interference and question, or refute any testimony or evidence presented.